Assembly Bill No. 2537

CHAPTER 241

An act to amend Section 10123.13 of, and to amend and renumber Section 10123.135 of, the Insurance Code, relating to insurance.

[Approved by Governor August 24, 2000. Filed with Secretary of State August 25, 2000.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2537, Thomson. Insurance: payment of contested health care claims: recertification of disabilities.

Existing law provides for the regulation of insurers by the Insurance Commissioner.

Existing law generally requires disability insurers to reimburse health care claims within 30 working days of receipt of the claim, unless the claim is contested, and provides that interest shall accrue with respect to uncontested claims remaining unpaid after 30 working days, as specified. A claim is contested if, among other things, an insurer has not received a completed claim and all information necessary to determine payer liability for the claim.

This bill would provide that interest shall also accrue on contested health care claims if an insurer has received all information necessary to determine payer liability and has not reimbursed a claim determined to be payable within 30 working days of receipt of that information.

This bill would also make a nonsubstantive technical change.

The people of the State of California do enact as follows:

SECTION 1. Section 10123.13 of the Insurance Code, is amended to read:

10123.13. (a) Every insurer issuing group or individual policies of disability insurance that covers hospital, medical, or surgical expenses, including those telemedicine services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested shall identify the portion of the claim that is contested and the specific reasons for contesting the claim.

(b) If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue and shall be payable at the rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(c) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. If an insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 working days of receipt of that information, interest shall accrue and be payable at a rate of 10 percent per annum beginning with the first calendar day after the 30-working day period.

(d) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

SEC. 2. Section 10123.135 of the Insurance Code, as added by Chapter 88 of the Statutes of 1999, is amended and renumbered to read:

10123.132. (a) Every disability insurer that covers hospital, medical, or surgical expenses and that reviews and approves the medical necessity or appropriateness of requests by providers prior to, or concurrently with, the provision of health care services to insureds, shall prominently indicate on each insured's identification card whether a separate telephone number must be called to verify eligibility for benefits and coverage.

(b) A written notice shall accompany the initial mailing of the insured's identification card modified pursuant to subdivision (a). The notice shall indicate that the insured's identification card includes a telephone number that may be used to verify eligibility for benefits and coverage. The notice shall also inform the insured that review and approval of a health care service based on medical necessity or appropriateness does not constitute eligibility for benefits and coverage pursuant to the policy or contract.

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